STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/20/2011

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JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN47250

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R0000	This visit was for a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00088447. Complaint IN00088447- Unsubstantiated due to lack of evidence. Survey dates: May 18, 19, and 20, 2011 Facility number: 004352 Provider number: 004352 AIM number: N/A Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN (5/18, 5/19, 2011) Census bed type: Residential: 32 Total: 32 Census payor type: Other: 32 Total: 32 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2.	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0116	Quality review 5/25/11 by Suzanne Williams, RN (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.			
	Based on record review and interview, the facility failed to have specific procedures written for the screening of prospective employees, in that the facility policy and procedure for abuse prohibition failed to include background screening. This deficient practice has the potential to affect all 32 residents. Findings include: A policy and procedure for abuse/neglect/exploitation, with an effective date of 6/2008, was provided by the Executive Director on 5/19/11 at 4:20 p.m. This policy failed to include, as a component, the screening of prospective employees. During an interview on 5/20/11 at 10:30 a.m., the Director of Wellness Services indicated she could not locate a policy and procedure for abuse that included screening in the policy. On 5/20/11 at 11:20 a.m., the Corporate Nurse Consultant provided a policy for	R0116	**Citation #1** **R 116** **410 IAC 16.2-5-1.4 (a)** **Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The policy and procedure was revised regarding screening of prospective employees in reference to abuse prohibition and background screening. The Residence Director and the Wellness Director were re-educated to this policy. The Residence Director and/or Designee	07/10/2011

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	incident reporting and reporting unusual occurrences and neither of these policies addressed the screening of prospective employees. During an interview on 5/20/11 at 3:50 p.m., the Corporate Nurse Consultant indicated that if screening isn't addressed in the policies and procedures provided, it's not in their policy.		will ensure the policy and procedure is followed as established within our ALC Resource Manual. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director will perform a random monthly review of employees at the Jewel House to ensure staff are screened appropriately to ensure abuse prohibition and background screening are completed per our policy. Findings will be reviewed within the next three months as to the plan regarding continued frequency of monitoring. Findings suggestive of compliance will meet the criteria for cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date:	

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R0123	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure personnel records were complete in that the employee records failed to have screening for a criminal history check, job descriptions, general orientations, resident rights inservices, and inservices for abuse prevention. This affected 3 of 4 employee records reviewed. (Employees #1, #2, and #7) Findings include: Employee records were reviewed on 5/20/11 at 10:00 a.m. Review of these records indicated the following: 1. Employee #1/Executive Director did	R0123	**Citation #2** **R 123** **410 IAC 16.2-5-1.4 (h) (1-10)** **Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employees #1, #2, and #7 had criminal background checks, signed job descriptions, general orientations, resident rights, and in-services for abuse completed by the Residence Director and added to their file. **How the facility will identify other residents having the potential to be**	07/10/2011

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	not have a general orientation, job description, or abuse inservice in the employee record. 2. Employee #2/Director of Wellness Services did not have a screening for a criminal history check, general orientation, or job description in the employee record. 3. Employee #7/CNA did not have a general orientation, job description, residents rights or abuse inservice in the employee record. During an interview on 5/20/11 at 12:30 p.m., the Director of Wellness Services and the Executive Director indicated they could not locate any of the missing information in the employee records.		**affected by the same deficient practice and what corrective action will be taken?** The Wellness Director reviewed employee files for criminal background checks, job descriptions, general orientations, resident rights, and in-services for abuse with no other findings. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and Residence Director were re-educated to our policy and procedure regarding criminal background checks, job descriptions, general orientations, resident rights, and in-services for abuse. The Residence Director will be responsible to ensure employee files are compliant with state residential regulation 410 IAC 16.2-5-1.4 (h) (1-10) Personnel. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/ or Designee will be responsible for performing a random ongoing monthly review of employee files for a period of three months to ensure compliance with criminal background checks, job descriptions, general orientations,	

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			resident rights, and in-services for abuse. Findings will be reviewed within the next three months as to the plan regarding continued frequency of monitoring. Findings suggestive of compliance will meet the criteria for cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date:	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to assure timely semi-annual evaluations were conducted and documented for each resident for 1 of 7 residents reviewed for semi-annual evaluations in a total sample of 7. (Resident #1) Findings include: Resident #1's clinical record was reviewed on 5-19-11 at 2:10 p.m. Review of the semi-annual evaluations indicated these had been conducted and signed on 5-2-2009, 10-6-2009, 9-30-10, and most recently on 5-2-2011. These dates	R0214	**Citation #3** **R 214** **410 IAC 16.2-5-2 (a)** **Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The Wellness Director upon hire had developed and implemented a spreadsheet to ensure semi annual evaluations were completed as indicated within our policy and procedure. Resident #1 had a re-assessment completed by the Wellness Director after performing an internal audit of residents utilizing our internal QA process upon hire in	07/10/2011

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	indicated a semi-annual evaluation would have been due on or around 4-6-10 and prior to the 9-3-10 evaluation. Another semi-annual evaluation should have been due on or around 3-30-11. In interview with the Director of Wellness Services (DWS) on 5-19-11 at 3:30 p.m., she indicated that when she began her position at this facility in January 2011, she found several (resident) charts that were behind [in paperwork documentation] and she has been working to get them all current. In interview with the Regional Corporate Nurse on 5-20-11 at 11:15 a.m., he indicated the Administrator and Wellness Director both became ill last fall. He indicated he and the current administrative team have been trying to locate any paperwork that is missing in the clinical records.		January and this issue had been corrected prior to survey. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Wellness Director upon hire had developed and implemented a spreadsheet to ensure semi annual evaluations were completed as indicated within our policy and procedure. The Wellness Director upon hire has conducted a QA of current residents and completed an updated re-assessment of residents utilizing our assessment tools per our policy. Prior to survey the Wellness Director had completed any update assessment of residents within the community and achieved compliance prior to survey. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The policy and procedure was reviewed with the Wellness Director however she was educated prior to survey and achieved compliance after her hire date in January. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The Wellness Director upon hire had developed and implemented a spreadsheet to ensure semi annual evaluations were completed as indicated within our policy and procedure. The Wellness Director upon hire has conducted a QA of current residents and completed an updated re-assessment of residents utilizing our assessment tools per our policy. The Wellness Director is currently performing an ongoing monthly review of residents utilizing a spreadsheet she developed and implemented to ensure our assessment tools and completed per our policy. **By what date will the systemic changes be completed?** Compliance Date:	

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident in that 2 of 7 residents in a sample of 7 did not have a service plan signed and dated by the resident. (Residents #20 and #8) Findings include:	R0217	**Citation #4 R 217 410 IAC 16.2-5-2 (e) (1-5) Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #20 & #8 had their assessments reviewed and signed by the residents and responsible parties. **How the facility will identify**	07/10/2011

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	A document titled "STATE OF INDIANA RESIDENCY AGREEMENT" was provided by the Executive Director on 5/18/11 at 2:05 p.m. The agreement indicated, but was not limited to: "...Assessment and Negotiated Service Plan. Prior to move-in or within fourteen (14) days of move-in, Residence staff, in consultation with You and Your health care providers, will evaluate Your supportive, personal care and health needs to develop an Assessment Score and Negotiated Service Plan. The Negotiated Service Plan will be signed by the Residence Director and You. Your needs will be reviewed semi-annually or in the event of a significant change in Your condition...." 1. Resident #20's record was reviewed on 5/18/11 at 1:25 p.m. The record indicated Resident #20 was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, insulin dependent diabetes mellitus, depression, anxiety, sleep apnea, insomnia, and osteoarthritis. An "ASSESSMENT and NEGOTIATED SERVICE PLAN SUMMARY" dated 2/23/2011 was provided by the Director of Wellness Services (DWS) on 5/19/11 at 10:40 a.m. and indicated this was the current service plan for Resident #20.		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Wellness Director and Residence Director implemented a system to ensure the Service Level Assessments and Negotiated Service Plans are reviewed and signed by the resident and responsible party if applicable per our policy and procedure. Residents were reviewed with no other findings. In the event the responsible party is required to sign the Service Level Assessment and Negotiated Service Plan and is unable to attend the meeting the assessment will be reviewed via a phone conversation and documented as to the date of the conversation. A copy will be placed within the chart for reference and the original will be sent onto the responsible party for signature with a self addressed envelope for return to the house. The signed copy will then be placed in the resident record. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director was re-educated to the policy and procedure regarding the Service Level Assessment	

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	The service plan indicated the next review date is 8/22/2011. The service plan was not signed nor dated by the resident. A note on the service plan indicated "mailed 4/7/11" and was signed by the DWS. During an interview on 5/19/11 at 12:25 p.m., the DWS indicated the service plan was sent to the POA because she pays the bills and wants to know the care levels. The DWS also indicated the residents are shown the service plans and they could sign [the service plan]. 2. Resident #8's clinical record was reviewed on 5-18-11 at 1:25 p.m. A document entitled, "Assessment and Negotiated Service Plan Summary" was identified by the Director of Wellness Services (DWS) as the current service plan for this resident on 5-19-11 at 10:40 a.m. The document indicated the review range as 4-26-11 with the review type as "180 day" and the next review date as		and Negotiated Service Plan. A plan has been developed by the Wellness Director and Residence Director to ensure the Service Level Assessment and Negotiated Service Plan is reviewed and signed by the resident and/or responsible party per our policy as to the services provided by the community. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/ or Designee will be responsible to perform a random ongoing monthly review of the resident Service Level Assessment and Negotiated Service Plan as to accuracy and completion of the assessment with appropriate signature from the resident and/or responsible party as indicated within our policy and procedure. **By what date will the systemic changes be completed?** Compliance Date:	

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	"10-23-11." She indicated the resident had been provided a copy of the document on 5-4-11 and has not given the facility a signed and dated copy of the service plan at this time. A handwritten notation was noted on page 1 of the document which indicated, "Given to resident to sign on 5-4-11."			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
	Based on record review and interview, the facility failed to ensure clinical records were accurately documented in regard to a code status for 1 of 7 residents, were complete and accurately documented in regard to status or well-being of 1 of 7 residents and systematically organized in regard to the monthly recapitulation (physician orders) for 1 of 7 residents in a sample of 7 residents reviewed for accuracy of clinical records. (Residents #1 and #8) Findings include: A policy entitled, "Documentation" with a revision date of 1/2006 was provided by	R0349	**Citation #5** **R 349** **410 IAC 16.2-5-8.1 (a) (1-4)** **Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #1 had their code status clarified with the family, resident, and the physician. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director reviewed resident records to ensure resident	07/10/2011

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	the Director of Wellness Services on 5-20-11 at 9:50 a.m. Under the sub-heading, "General Documentation Rules," item #4 indicated, "Write the date and time on every entry." Item #11 indicated, "Sign each entry with your complete name and title or your first initial, last name, and title." Under the sub-heading, "Legal and Ethical Considerations," item #3 indicated, "The law assumes a resident's record is accurate. This means that it does no good to tell the court that you provided a service or assisted with a medication but forgot to write it down. **If something isn't documented, in the eyes of the law it didn't' happen."** 1. Resident #1's clinical record was reviewed on 5-19-11 at 2:10 p.m. A document identified as "CPR Agreement FM-OC105" with a revision date of 4/2003 indicated Resident #1's family member/emergency contact/power of attorney signed the document to indicate that no resuscitation would be provided in the event of a cardiac or respiratory arrest. This document was signed and dated 5-2-2009, the date of admission to the facility. This document indicated, "No resuscitation should be attempted - Resident is on DNR status (do not resuscitate - No Code). (sic) This has		code status was delineated. No other residents were found to be affected. The Wellness Director reviewed resident records and filed records in accordance with our policy regarding service binder chart order. The Wellness Director and/or Designee will be assigned to ensure resident service binders are systematically organized as indicated within our policy. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director was re-educated to our policy regarding code status and service binder chart order. The Wellness Director and/or Designee will be assigned to ensure resident service binders are systematically organized per our policy. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director will perform a random monthly review of employee files and resident code status for a period of six (6) months. Findings will be reviewed within the next six months as to the plan regarding continued frequency of monitoring. Findings suggestive of	

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	been discussed with the resident and family." Review of the current recapitulation orders for May 2011 indicated the resident as, "Full Code." According to the same document above, this would indicate, "Begin resuscitation with CPR [cardiac pulmonary resuscitation], after calling 911," in the event of a cardio-pulmonary arrest. In interview with the Director of Wellness Services on 5-20-11 at 3:30 p.m., she indicated she had no idea [of the discrepancy]. She indicated she would immediately contact the physician to clarify the code status. 2. Resident #8's clinical record was reviewed on 5-18-11 at 1:25 p.m. Resident #8's diagnoses included, but were not limited to congestive heart failure, coronary heart disease, type 2 diabetes mellitus, history of previous coronary artery bypass graft (heart surgery to repair blockages), fatigue, vertigo (dizziness.) "Resident Services Notes," dated 4-3-11 with no time specified indicated "Took res. (resident) back from lunch in wheelchair. Done (sic) vitals [signs], res. feeling bad. 1:40 res was took (sic) out by		compliance will meet the criteria for cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date:	

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		A. BUILDING 00 B. WING	05/20/2011

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	ambulance to (area hospital)." This notation was signed by "CNA (staff member's first name only, no last name listed.") Documentation did not indicate the results of the vital signs, if the licensed nurse, physician or family had been informed of the resident's status and transfer to the area hospital. 3. Resident #1's clinical record was reviewed on 5-19-11 at 2:10 p.m. In review of the clinical record, it was observed the section of the record with the recapitulation orders were not systematically organized. The record indicated the physician orders section contained the following information: recapitulation orders for 5/11, followed by recapitulation orders for 11/09 and 12/09, a faxed order sheet dated 4-21-11, recapitulation orders for 4/11, a faxed order dated 3-10-11 and recapitulation orders for 2/11. In interview with the Director of Wellness Services on 5-19-11 at 4:00 p.m., she indicated the facility does not have a specific policy on chart order. She indicated since she came to the facility in January 2011, she has utilized a corporate document entitled, "Resident Services Binder Order," for any residents that have been admitted. She indicated the chart should be organized in			

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	chronological order with the most current information on top.			
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to maintain an infection control program in that a blood glucose meter was not disinfected after use with one resident and before use on another resident, and failed to ensure the wore gloves while using the meter. This affected 2 of 3 residents who require assistance with blood glucose monitoring in the sample of 7. (Residents #13 and #25) Findings include: Manufacturer's recommendations for the glucose meter were provided by the Director of Wellness Services (DWS) on 5/20/11 at 9:50 a.m. The instructions included, but were not limited to: "Healthcare Professionals should adhere to Standard Precautions and disinfection procedures when handling or using this device for testing. ALL parts of the TRUEbalance Blood Glucose Monitoring System are considered potentially infectious, and capable of transmitting blood-borne pathogens...If dedicating	R0406	**Citation #6** **R 406** **410 IAC 16.2-5-12 (a)** **Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The licensed staff were re-educated to our policy and procedure and the manufacturers recommendations regarding standard precautions and proper disinfection procedures when handling or utilizing the blood glucose monitoring devices.	07/10/2011

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	blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use following the guidelines found in Meter Care, Cleaning/Disinfection. We suggest cleaning and disinfecting the Meter after each use to prevent the transmission of blood-borne pathogens....Contact with blood presents a potential infection risk. A new pair of gloves should be worn before testing each patient. We recommend one meter per patient. We suggest to clean and disinfect Meter between patients when Meter is used on multiple patients...To clean and disinfect Meter, use PDI Super Sani-Cloth Germicidal Disposable wipes...." A policy for infection control, with an effective date of 6/2008, was provided by the DWS on 5/20/11 at 9:50 a.m. The policy included, but was not limited to: "...b. Appropriate personal protective equipment (e.g. gloves) must be used during any task that involves the potential for skin contact with body fluids (e.g...assisting with glucometer check, etc.)...." During the medication pass observation on 5/19/11 at 4:30 p.m., a blood glucose check was done on Resident #13 by LPN #15. After the blood glucose check, the LPN placed the blood glucose meter in		**How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director will perform a random daily walking rounds of the Residence for a period of three months to ensure licensed staff is properly disinfecting the blood glucose monitoring device per the manufacturer guidelines and adhering to our policy pertaining to standard precaution. Findings will be reviewed within the next six months as to the plan regarding continued frequency of monitoring Findings suggestive of compliance will meet the criteria for cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date:	

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	the top drawer of the medication cart without disinfecting the blood glucose meter. LPN #15 then went to Resident #25's room to check this resident's blood glucose level. The LPN used the same blood glucose meter as before and did not disinfect the meter. The LPN entered the room and did not wear gloves during the first attempt to obtain a specimen to check the blood glucose level. She returned to the medication cart to get another lancet when the first attempt failed to result in enough blood to check the glucose level. When queried if she cleaned the blood glucose machine between residents, the LPN said "no, residents are supposed to have their own machine." The LPN indicated Resident #13 had a new meter, but the test strips for the new meter had not come in yet, and he still had test strips for his old meter. When queried about wearing gloves, she said she "forgot to stick them on." She obtained an alcohol wipe and cleaned the lancet device but did not clean the blood glucose meter. During an interview on 5/20/11 at 3:50 p.m., the Director of Wellness Services indicated the facility does not have the Sani-Cloth Germicidal Disposable wipes as every resident is supposed to have their own glucometer.			

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